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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Rwanda

The Executive Director recommends that the Executive Board approve the country programme of Rwanda for the period 1993-1997 in the amount of $9,900,000 from general resources, subject to the availability of funds, and $13 million in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. Rwanda is a country with limited economic potential, a high population growth rate (4.8 per cent per year) and one of the smallest land areas in Africa. In 1991, the population rose to 7.3 million, an increase of 50 per cent over a 10-year period, with an average population density of 271 persons per square kilometre. The average size of family farms and the fertility of the soil are on the decline. There are few opportunities for off-farm employment. In 1989, large parts of the southern portion of the country suffered from famine. Mere survival is becoming increasingly difficult.

2. Almost one out of five children weighs less than 2.5 kilograms at birth. Twenty per cent of children do not live to see their fifth birthday. About 50,000 children under one year of age die every year, 135 every day. These deaths are the result of the cumulative and synergistic effects of frequent infections and chronic malnutrition. The most common diseases directly responsible for child malnutrition and death are malaria, acute respiratory infections (ARI) and diarrhoea. More than 50 per cent of five-year-old children suffer from stunting; and 6 per cent of children under three years of age suffer from severe and 25 per cent from moderate malnutrition. Intestinal parasites and micronutrient deficiencies, including deficiencies in vitamin A, iron and iodine, are widespread. Water consumption is about 10 litres per person per day in rural areas. Only 40 per cent of households have safe latrines that are easy to use. Twenty per cent of mothers use oral rehydration therapy (ORT) at home. Eighty per cent of women practise exclusive breast-feeding for the first six months of a child's life. Weaning foods and practices are often inappropriate.

3. Most women are subsistence farmers. These women and their children survive on food they grow on their husbands' small farms, supplemented by meagre non-farm incomes. The average woman bears more than eight children and spends between 15 and 20 years of her life pregnant or breast-feeding. The contraceptive prevalence rate was estimated at 12.6 per cent in 1991. More than 80 per cent of pregnant women undergo two antenatal visits, but women do not reduce their workload during pregnancy and breast-feeding. Average weight-gain during pregnancy is about 2 kilograms. At-risk pregnancies account for up to 30 per cent of all those seen in health centres. No reliable figures are available, but the maternal mortality rate (MMR) is thought to be about 300 per 100,000 live births.

4. Only an estimated 40 per cent of women are literate. The high number of early school leavers hinders attempts to increase the literacy rate. Enrolment is roughly equal for boys and girls during the first three years of primary school, but the drop-out rate for girls begins to climb from the age of 12 years onwards as girls assume greater household and child-care responsibilities.

5. In 1991, more than 1 million children attended primary school, 49.8 per cent of whom were girls. Three out of four children start primary school at the age of seven years, but only one third of them complete primary education. The student/teacher ratio is more than 90:1 in the first three

years of primary school. Forty-five per cent of primary school teachers are unqualified. Many schools lack desks and blackboards, and parents are too poor to pay the increasing costs of education. Primary school is free and compulsory, but many families find it difficult to meet the indirect costs of education: uniforms; reading and writing materials; and the costs in terms of the loss of children's work in fetching wood and water, carrying out essential agricultural tasks and, in the case of girls, looking after younger siblings.

6. Most Rwandans live within five kilometres of a health centre, but because of the hilly terrain, almost one half of them have to walk more than one hour to reach it. The quality of service is low owing to the lack of qualified staff; the difficulty of providing a reliable flow of essential drugs; poor training, motivation and supervision of staff; and the lack of community participation in the management of health problems and services. At health centres, the integration of maternal and child health (MCH), family planning and nutrition services and the standardization of diagnosis and treatment are major challenges. The health information system generates useful reports, but these have not been of assistance to communities in taking responsibility for their own health.

7. High fertility rates, heavy workloads and declining incomes put the survival and development of women under increasing stress. Women work long hours to grow food and to fetch wood and water, as well as to feed, care for and educate their children. They cannot legally own land, benefit little from improved farming inputs and have limited access to a few years of basic education. They control neither the number of children they have nor household income and assets. It is remarkable that four out of five children survive to the age of five years. However, current conditions do little to enhance the situation and status of women, who face increasing impoverishment and marginalization.

8. Since 1983, the acquired immune deficiency syndrome (AIDS) epidemic in urban areas has become a cause of increasing concern. At the end of 1991, between 150,000 and 220,000 people were thought to be living with the AIDS virus. Human immunodeficiency virus (HIV) prevalence rates among women attending antenatal clinics were 26.7 per cent in urban areas and 3.3 per cent in rural areas. In 1991, between 7,000 and 10,000 babies were estimated to have been born HIV-positive. There are more than 6,000 AIDS orphans in Kigali. HIV-positive rates are three times higher among women than among men between the ages of 15 and 19 years old.

9. Per capita gross national product was estimated at $260 in 1991. Since 1987, the fall in the world price of coffee has caused an economic crisis. Coffee accounted for 84 per cent of exports in 1986, but revenues fell by 40 per cent between 1987 and 1991. External and internal debt repayments account for almost 30 per cent of State revenues.

10. Rwanda is in transition to a multi-party democracy despite sporadic ethnic violence. Since October 1990, armed incursions by exiles operating along the northern frontier have destabilized the country. The defence budget quadrupled between 1989 and 1991 and now accounts for more than 30 per cent of the national budget. A cease-fire has been holding since July 1992.

11. A structural adjustment programme will run until the end of 1993. It aims to liberalize the economy, cut subsidies to coffee producers and freeze salaries and recruitment. Between 1990 and 1992, national expenditure on health and education fell from 25 to 17 per cent. With 20 per cent inflation, social expenditure per inhabitant is falling by more than 10 per cent per year. External budgetary support and food aid are likely to remain necessary. The survival and development of children and women depend not only on increased efficiency and relevance of basic services, but also on the transition to a more participatory society and peace.

PROGRAMME COOPERATION, 1988-1992

12. The 1988-1992 country programme, which included four sectoral programmes, aimed at contributing to the reduction of the infant mortality rate (IMR) and the under-five mortality rate (U5MR) and enhancing the well-being of children and women.

Health and nutrition

13. Health and nutrition accounted for 40 per cent of expenditures and consisted of six projects: expanded programme on immunization (EPI); MCH; control of diarrhoeal diseases (CDD); nutrition; essential drugs/Bamako Initiative; and AIDS prevention.

Expanded programme on immunization

14. Rwanda was among the first countries to reach universal child immunization (UCI) in 1989 and has since maintained coverage for all antigens at more than 80 per cent. Vaccination is available at all 286 health centres. A February 1992 national coverage survey found the following coverage for children under one year of age: anti-tuberculosis vaccine, 94 per cent; polio vaccine and three doses of combined diphtheria/pertussis/tetanus vaccine, 85 per cent; and two doses of tetanus toxoid (TT2), 88 per cent. Measles no longer features on the list of the 10 leading childhood diseases. Reported cases of poliomyelitis have declined to the point where eradication may be possible by 1995. Political commitment, logistics and social mobilization were essential for the achievement of UCI. Many agencies took part in the effort. UNICEF provided all vaccines except for polio, and strengthened the cold chain and logistics throughout the health system. More than 600 health workers underwent training. The project has made a significant impact on targeted diseases and has strengthened capacity in planning, implementation and monitoring.

Essential drugs/Bamako Initiative

15. The Ministry of Health launched a Bamako Initiative project in 1989. The pilot phase aimed to test the feasibility of cost recovery at the community level. The initial response was high and 97 health centres are now using the scheme. The project is strengthening community participation in and management of health services through training, monitoring and regular supervision.

AIDS prevention

16. In 1988, studies of knowledge, attitudes and practices about AIDS provided the basis for education and training in AIDS prevention among in-school and out-of-school youth. The project introduced AIDS messages in school curricula, textbooks and teaching materials. More than 5,000 primary and secondary school heads and teachers underwent training. A 1991 evaluation showed that students had increased their understanding of AIDS transmission and changed their attitudes towards AIDS victims, but behavioural change was more difficult to assure. The evaluation suggested decentralized decision-making and a less formal approach for out-of-school youth. The project provides training and support for youth leaders chosen by their peers in six pilot sectors. It encourages group discussions and social and sporting activities. The aim is to develop group awareness and solidarity among vulnerable unemployed youth, especially girls.

Other health and nutrition projects

17. To institutionalize weighing during pregnancy, UNICEF gave adult weighing scales to all health centres and helped in the design of a health and nutrition card for mothers. More than 1,700 traditional midwives received training and delivery kits, but follow-up was difficult. More than 80 per cent of women undergo two prenatal consultations and receive TT2, but most mothers call on midwives only after problems have developed during childbirth. A national strategy for MCH, incorporating health, family planning and nutrition, came into effect in 1991.

18. In 1992, the "baby-friendly" hospital initiative began in the two leading hospitals by producing posters, promoting the "Ten steps to successful breast-feeding" and training a team of trainers. A study at Kigali Hospital Centre found that HIV transmission was possible if the mother became HIV-positive while she was breast-feeding. In an area where infectious diseases cause most child deaths, this does not justify a reduction in the promotion of breast-feeding, except when mothers are confirmed as HIV-positive. In such cases, the mother will be advised of the risks, given the choice whether to breast-feed or not, and provided with medical supervision for alternatives to breast-feeding.

19. Dehydration caused by diarrhoea remains a major cause of child mortality. The main strategies for CDD are to prevent diarrhoea and improve case management. Since 1988, oral rehydration sachets have been available at all health centres and more than 7,000 health workers have undergone ORT training. The area of CDD has lacked leadership and a coherent plan of action. Senior health workers lack ORT training. The mid-term review pointed to the need to stress breast-feeding, feeding during episodes of diarrhoea and the integration of diarrhoea control and nutrition.

20. Traditionally, nutrition activities have been curative. Since 1988, UNICEF has supported the integration of nutrition and growth monitoring to transform the old vaccination cards into child health cards. While supporting training in therapeutic nutrition, the project also funded studies on weaning practices, household food consumption budgets and malnutrition. Growth monitoring and promotion activities were introduced among pregnant women and

vulnerable children in two prefectures. In 1991, the Ministry of Agriculture agreed to include nutrition and household food security in questionnaires to monitor nutritional status, food practices and coping mechanisms among 2,500 sample households throughout the country. The project supported the iodization of salt and vitamin A and iron supplementation through health worker training and supplies. Artificial distinctions between health and nutrition persist, with health workers needing time and guidance on how to integrate the promotion of good nutrition into hectic schedules.

Water supply and sanitation

21. The water supply and sanitation programme for 1988-1992 aimed to improve the quality of water and reduce water-related diseases in rural areas. A national inventory located and listed more than 25,000 water sources. Of these, 1,700 sources were protected, and washing slabs were constructed at 1,100 of the protected sources. Eleven gravity-fed water supply systems were completed, serving 55,000 people, and 146 water technicians were trained. To improve the availability of water in the household, 50 water storage tanks made of ferro-cement or bamboo-cement were built. Through the hygiene and sanitation project, 45 school latrine blocks and 250 family latrines were constructed. Posters and pamphlets for hygiene education were also produced and distributed. Pilot activities included the installation of manual pumps on springs and hand-dug wells. UNICEF also intervened to provide water, jerrycans and latrines for war-displaced people. At present, the programme is in need of more qualified personnel. Sector planning, monitoring and maintenance also require strengthening. Many women are treasurers of water management committees, but on the whole, their representation remains low. Community contributions accounted for 20 per cent of construction costs, but have decreased during the transition to multi-party democracy. The mid-term review stressed management and maintenance, and the need to link water supply with sanitation, CDD and household food security.

Household food security

22. The programme aimed at increasing commitment to household food security and nutrition; improving the availability, processing and storage of food in the household; and increasing the income and reducing the workload of women. Activities included loan guarantee and revolving credit funds for women for small and micro-enterprises, for which the repayment rate is more than 95 per cent. The project supported 40 training sessions for female entrepreneurs and 100 workshops for non-governmental organizations (NGOs) supporting women's groups. It also provided training support for 50 women's groups and cooperatives for the improvement of food distribution, storage and marketing. Start-up has been slow, but the project has succeeded in creating acceptance of the need for credit to women entrepreneurs.

Literacy and education

23. To promote basic education and literacy, the programme offered support for improving the quality and quantity of teachers. Primary school curricula were adapted to rural life and more than 400 teacher trainers were retrained. Studies and surveys brought education statistics up to date. Training was offered to 180 play-school teachers, and literacy instructors and supervisors

were trained to serve in more than 1,300 literacy centres. Fifty rural communities were served by teaching materials, vehicles and social mobilization activities. The lack of supplementary funding prevented services to the remainder of the 145 communes. However, only 15 per cent of the more than 300,000 literacy students passed the literacy test. The programme suffered from the conceptual weaknesses of a mass literacy campaign based on top-down mobilization ill adapted to the circumstances and needs of the beneficiaries. A 1992 review concluded that increased access to primary education is the best strategy for promoting basic skills and knowledge and reducing illiteracy. The review recommended the improvement of the learning environment, the provision of learning materials to reduce school drop-out and repeater rates and a strategy of focused, functional literacy promotion, emphasizing literacy for those who need it. The review also recommended a greater focus on operational research and a coordinated effort in the education sector in support of the follow-up to the World Conference on Education for All (WCEFA).

Lessons learned

24. The programme succeeded in reaching and maintaining UCI, starting Bamako Initiative activities in one third of health centres, reintroducing nutrition as a major concern and strengthening support to women's groups. In the area of education, weaknesses remain.

25. The experience gained from the current programme cycle showed that studies and evaluations made an important contribution to the social mobilization process. The evaluations have shown that the programme strategy should be more flexible to respond to the continuing emergency situation. Another important lesson was that the monitoring and evaluation system needs to be strengthened so that cost-efficiency and programme impact can be measured. The major priorities now are to introduce an emphasis on the learning process and to strengthen programme integration and community participation, especially by women.

Country programme preparation process

26. Training for all staff took place with the Burundi office in June 1991. In November 1991, work began on the situation analysis and the Ministry of Planning formed a programming team. The exercise took 10 months, with constant headquarters and regional office support. After an orientation workshop for government counterparts in January 1992, the Regional Director, the Chief of the Bamako Initiative Management Unit and programme staff from the region and headquarters took part in the strategy meeting in mid-February. The workshop analysed problems at household, community and central government levels and identified major areas for programme intervention. A March 1992 in-house retreat refined the country programme structure. The preparation of the programme plan of operations began in April, with six teams of government, NGO and UNICEF programme staff holding meetings over a period of one month. This process led to a programming retreat in May 1992. In mid-July, the preview meeting included an in-house revision of programme documents, and a one-day formal preview, chaired by the Director of Planning and involving more than 60 government and NGO representatives. The UNICEF office completed programme and budget documents by September 1992.

RECOMMENDED PROGRAMME COOPERATION, 1993-1997

Recommended general resources: $9,900,000
Supplementary funding: $13,000,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Primary health care	3 465	5 200	8 665
Basic education	1 980	1 950	3 930
Water supply and sanitation	1 485	4 550	6 035
Household food and income security	1 485	1 300	2 785
Information, organization-building and advocacy	1 485	-	1 485
Total	9 900	13 000	22 900

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Major national goals

27. The President of the Republic of Rwanda attended the World Summit for Children (WSC) and signed its Declaration and Plan of Action. The Ministry of Planning has completed a national programme of action (NPA) and has set up a national commission for Summit follow-up, which includes multisectoral representation from members of the United Nations system, the diplomatic corps, NGOs, the media and different ministries. The NPA includes the seven major WSC goals, with additional goals for family planning and the control of AIDS. The NPA aims at almost complete vaccination coverage by the year 2000 and the elimination of neonatal tetanus and the eradication of indigenous polio by 1995. The 1993-1997 programme of cooperation aims to advance the following national goals and objectives, reflected in the NPA for children.

MAJOR NATIONAL PROGRAMME OF ACTION GOALS FOR RWANDA

		1990	1997	2000
1.	IMR (per 1,000 live births)	117	105	90
	U5MR (per 1,000 live births)	198	170	150
2.	MMR (per 100,000 births)	300	255	200
3.	Malnutrition			
	- severe (% under 5 years)	7	6	5
	- moderate (% under 5 years)	23	19	17
4.	Water			
	- % access to safe drinking water	65	75	80
5.	Sanitation			
	- % access to sanitary means of excreta disposal	41	60	70
6.	Net school enrolment rate			
	- % age 7 to 14 years old	62	70	80
7.	Female adult literacy rate			
	- % of population over 15 years old	37	50	60
8.	Contraceptive prevalence rate			
	- % child-bearing couples	12.6	30	48
9.	HIV prevalence in population 15 to 19 years old	(No data available)		

Country programme goal and objectives

28. The programme goal is to reinforce the country's capacity to increase the chances of survival and to enhance the development potential of its children and women. There are four major programme objectives for the end of 1997: (a) to reduce U5MR from the 1990 NPA baseline indicator of 198 per 1,000 live births to 170 per 1,000 live births, an estimated reduction of 10 per cent; (b) to reduce MMR from 300 to 255 per 100,000 births, an estimated reduction of 15 per cent; (c) to reduce chronic malnutrition among children under five years of age from 30 to 25 per cent, an estimated reduction of 20 per cent; and (d) to reduce the socio-economic vulnerability of the poorest households.

29. The causes of the high IMR, MMR and malnutrition rates and of the socio-economic vulnerability of many households are complex and interactive. The structure of the new country programme will allow each sectoral programme to contribute to the achievement of the following intersectoral objectives: (a) to reduce the mortality rate attributable to malaria among children under five years of age from 90 to 70 per 1,000 live births; (b) to reduce the mortality rate attributable to ARI among children under five years of age from 40 to 30 per 1,000; (c) to reduce the mortality rate attributable to diarrhoeal

diseases among children under five years of age from 22 to 18 per 1,000; (d) to reduce the percentage of children who lose weight during weaning by one third; (e) to increase the percentage of women who gain at least 5 kilograms during pregnancy by half; and (f) to increase the proportion of women with an interval of 24 months between two deliveries by 50 per cent.

30. The country programme will consist of five programme sectors and 11 projects. By placing a set of specific, quantified, cross-cutting objectives high in the hierarchy of objectives, the programme takes into account the synergistic impact of activities in different sectors. This formalizes the intersectoral nature of activities, encourages integration and reduces duplication. At the sectoral programme level, objectives are qualitative in recognition that activities within each programme will work synergistically towards measurable outcomes at a higher level and across the whole country programme. Projects within the programmes have quantified output objectives that should be easy to evaluate using a desk-top review of programme documentation, including regular reports and programme field visits.

Programme strategy

31. The programme strategy is based on the Bamako Initiative, WCEFA, the Convention on the Rights of the Child and WSC, as adapted to the national context. The programme will promote simple as well as complex but achievable measures such as vaccination, ORT, breast-feeding, hand-washing with soap, spring protection, functional literacy and the empowerment of women's groups. Individuals, households and groups will be assisted to acquire basic knowledge and skills by improving the access to and use of information. In the transition to a decentralized, pluralistic system, the programme will promote dialogue between basic service providers and the population. This will call for a change in approach by community workers and the strengthening of structures for community participation, along with attention to greater relevance and accountability. Priority will be given to women and girls. Each project will increase and reinforce women's participation in decision-making. Each sectoral programme has a training component which will build national, regional and local capacity. The programme will collaborate with church groups and NGOs working at the commune level. In the current context of military and political instability, climatic fluctuations and structural food deficits, UNICEF will take measures to help the country prepare for and respond to emergencies. Strengthening and accelerating child survival measures in the country programme are seen as essential elements of this response.

32. The major programme thrusts are the maintenance of UCI, the control of infectious diseases, the strengthening of basic education, the protection of the coming generation against HIV infection and the improvement of resource management in vulnerable households. The sectoral programme components will stress decentralization and collaboration among different services, the convergence of activities and services, the improvement of the quality and accountability of services, the promotion of equity of access to services and community participation. Projects will build synergy around major high-impact programme areas by integrating interventions in water supply, literacy and household food security around health centres implementing the Bamako Initiative and in 20 communes that will serve as demonstration areas.

Primary health care

33. The programme will strengthen the capacity of the health system to provide a set of essential services according to the principles of the Bamako Initiative and to reduce the incidence of those diseases that contribute the most to mortality. Specific objectives are to reduce the incidence of measles from 80 to 40 per 100,000 population by the end of 1997; to eliminate neonatal tetanus and eradicate poliomyelitis by the end of 1995; to reduce the proportion of women suffering from anaemia from 50 to 30 per cent; to reduce the rate of iodine deficiency disorders to less than 10 per cent; and the rate of vitamin A deficiency to less than 0.5 per cent of children under five years of age. The programme covers the whole country and will target 1.5 million children under five years of age and 460,000 pregnant women. The programme consists of two projects:

(a) The health system management project will strengthen the planning, organization, coordination, monitoring and evaluation of primary health care (PHC) activities at national and regional levels. The project will promote the rational management and use of resources at health centres, and standard diagnosis and treatment of common ailments. A structure for efficient essential drugs supply management will be established and a contribution will be made to the initial stock of drugs. Community participation in health services will be strengthened through support to health centre management committees, with increased female representation. The project includes social mobilization and operational research;

(b) The MCH project will provide a minimum package of integrated essential services at all health centres. These include EPI, growth monitoring and nutrition promotion; malaria, the control of ARI and CDD; safe motherhood and family planning; and control and prevention of sexually transmitted diseases and AIDS. The project aims to increase quality and coverage by training, supervision, monitoring and social mobilization.

Basic education

34. The programme aims to improve basic survival and development knowledge and skills, especially among women and girls. Specific objectives are to increase the percentage of children between the ages of 7 and 14 years attending primary school from 62 to 70 per cent and to reduce the drop-out rate for girls at the end of the third year of primary school from 14 to 8 per cent. The programme will also increase the literacy rate for women and girls from 37 to 50 per cent. An AIDS prevention project in the education sector will reduce the rate of HIV prevalence and the percentage of HIV-positive women in the 15- to 19-year-old-age group. The protection and community care of children in difficult circumstances because of AIDS will be improved. The programme consists of three projects:

(a) The formal education project will assist in setting up a national commission to follow up on WCEFA and support the retraining of unqualified primary schoolteachers; the revision of curricula in line with the TURWANE KU BUZIMAR, the Rwandan version of Facts for Life; and the strengthening of the supervision system. Prototype teaching materials will be developed and

produced, and a revolving fund will be set up to help students gain access to reading and writing materials;

(b) The non-formal education project will focus on promoting functional literacy among women's groups in the catchment areas of Bamako Initiative health centres, making optimal use of Facts for Life. Activities include the training of literacy instructors and regular monitoring and supervision;

(c) The AIDS prevention project will support teacher training for AIDS prevention in all primary schools and out-of-school activities to motivate students against AIDS. For out-of-school children, the project will extend focus group approaches to all communes, which will involve awareness creation activities, the production and dissemination of educational messages as indicated in Facts for Life, the formation and support of groups, the training of group leaders and supervision. The AIDS prevention project is national in scope and will benefit an estimated 1.5 million young people, more than 800,000 of whom are women and girls.

Water supply and sanitation

35. The programme aims to increase the availability of safe water supplies and to improve environmental hygiene in the household. It also aims to reduce the time spent by women and children collecting water and firewood, while protecting the environment by preventing damage of the sources. Rural access to safe water will be increased from 65 to 75 per cent and the average amount of water used will be increased from 10 to 20 litres per person per day. The distance between the water source and the home will be reduced. In demonstration areas around health centres, the programme will increase access to safe latrines from 41 to 60 per cent and cut the cost of family latrines by half. The programme includes two projects:

(a) The water supply project will improve and protect 1,500 spring catchments with small water storage tanks and laundry slabs. Gravity-fed water supply systems will also be constructed, with distribution systems totalling 200 kilometres and 1,200 household water storage tanks in iron- or bamboo-cement. Hand-pumps will be installed on drilled boreholes and improved wells on a pilot groundwater potential. Other activities will include support for a water sector coordination committee and the introduction of the water supply and sanitation monitoring system. Each water point will have a management committee with at least one woman member. Masons, water technicians and pump attendants will be trained; techniques for filtering water in the household will be tested; and seedlings will be provided for the protection of sources. In addition, rapid response to emergencies will be ensured;

(b) The hygiene and sanitation project will support the construction of 500 public ventilated improved latrine blocks at health centres, schools and other suitable places. The project will set up production sites for reinforced latrine slabs and train 800 community workers in hygiene promotion. Education messages on safe hygiene and sanitation practices will be developed and disseminated. The project will benefit a population of 950,000, mainly women and children, who are responsible for 80 per cent of the work associated with water supply construction and the collection of water for household use.

Household food and income security

36. The programme aims to improve the management, control and creation of resources in the household to better meet basic needs. Women's access to credit, agricultural inputs and training will be increased. The main objectives are intersectoral: reductions in chronic and acute malnutrition and the incidence of low birth weight and weight loss during weaning; and increases in weight gain during pregnancy. The programme will focus on children under three years of age and pregnant and lactating women. It will target low-income women, female heads of household and households with less than 0.5 hectares of land in 20 demonstration communes. The programme consists of two projects:

(a) The household revenue and resource management project will provide training for members of women's groups, agricultural extension agents and community workers in agricultural and animal husbandry techniques, the use of improved seeds and fertilizers and micro-enterprise development. Credit and savings schemes for women's groups and households with little access to land will also be supported. The project will distribute seedlings for growing trees, promote improved stoves to reduce the consumption of firewood and encourage early child care development by supporting community-based systems for crêches and safe child care;

(b) The food security and feeding practices project will improve weaning practices and promote exclusive breast-feeding. A "baby-friendly" initiative will promote breast-feeding support groups and education and mobilization on the special needs of children and pregnant and lactating women. Community-based growth promotion, nutritional surveillance in famine-prone areas, improved and enriched weaning foods and improved food preservation and storage will also be supported.

Information, organization-building and advocacy

37. The programme aims to stimulate dialogue and action at all levels of decision-making to solve the priority problems of children and women. It also aims to sensitize decision makers to the needs of children and women through advocacy for the implementation of the NPA. In addition to national advocacy coverage, the programme will operate in 20 communes, with an estimated population of about 1 million, where it will test and replicate the community-based information and organization project. There will be 26 sentinel sites, with a sample of 4,000 households and a population of 20,000 people. The programme consists of two projects:

(a) Community-based information and organization-building, which will empower the population to take responsibility for solving local problems by strengthening the capacity of community members to assess and analyse priorities and to take action through community organization. The project will stress beneficiary participation in planning and managing services provided by projects in PHC, basic education, water supply and sanitation, and household food and income security programmes, as well as participation in social mobilization activities based on Facts for Life. The discussion of information collected in the community on problems affecting children and women will be central to the learning process of the project. Community-based information systems will use sentinel sites to monitor the conditions of children and

women. The discussion and analysis of results by service providers and community representatives will improve the relevance, efficiency and accountability of services. The project will provide technical support to community organizations and project management committees. Activities include community surveys, the training of committee members and community workers, monitoring and evaluation, and operational research;

(b) The advocacy project will sensitize decision makers to the importance of implementing policies and increasing budgets for activities that benefit children and women. The project includes support for a WSC national follow-up unit. Regular consultation meetings will be sponsored at the national level to discuss progress towards the Summit goals and the results of community surveys. The mass media will receive technical support. Communication materials will be provided on topics relevant to World Summit follow-up.

Monitoring and evaluation

38. The information, organization-building and advocacy programme will link NPA goal monitoring, communication, research and country programme monitoring and evaluation. The programme will use the human, financial and organizational resources of the line ministries implementing other sectoral programmes to carry out measurement and assessment activities once every three or four months. Community workers and members of project committees will carry out surveys to get recent information and maintain an up-to-date "rolling" situation analysis covering NPA goals and quantitative and qualitative information on programme impact, as well as the impact of the lessons learned by the recipients of Facts for Life, coverage and cost. Advocacy efforts will benefit from the feedback of survey results from the household to the national level. UNICEF will train people from communities and from different levels of the service delivery system in monitoring. At each sentinel site, committees and community groups will select research priorities, choose the methodologies, participate in field work and analyse and feedback results. The programme will stress greater understanding of beneficiary perceptions of problems. Annual programme reviews, a mid-term review in 1995 and an external evaluation in 1996 will be carried out.

Coordination with other agencies

39. The programme will build on the cooperation with other agencies that developed during the programme preparation exercise. The programming cycles of the United Nations Development Programme, the United Nations Population Fund (UNFPA) and UNICEF have been synchronized to strengthen the synergistic effect of United Nations interventions. Each agency will contribute to the reduction of poverty through a coherent response to the growing gap between usable land and population. The World Health Organization (WHO), UNFPA and UNICEF will focus on contributions in health, education, family planning and food and income security at the household level. Collaboration between WHO and UNICEF will remain crucial to success. In a situation of vulnerability to famine, collaboration between the World Food Programme and UNICEF will strengthen the existing coordinated response to emergencies. Donor agency coordination is a major issue. UNICEF already collaborates with many agencies in PHC, water supply and sanitation and education, including the United States Agency for International Development, Rotary International, and bilateral agencies from

France, Belgium and Germany in PHC and the World Bank and UNDP for the national programme of social action under structural adjustment. Collaboration with NGOs and church groups will be strengthened in line with the trend towards decentralization.

Programme management

40. The management objectives for the 1993-1997 country programme are: to allow for the adequate staffing of new programme activities in community-based information systems and monitoring the goals for the 1990s; to provide staff to implement commitments to Education for All and AIDS prevention; and to strengthen office capacity in information resource management and secretarial and clerical support. While the heads of four sectoral programmes will report to the programme officer, the information, organization-building and advocacy programme will be run by national Professionals reporting to the representative. The revised 1992-1993 budget proposes the establishment of one international Professional post in basic education, two national Professional posts in basic education and household food and income security and three secretarial/clerical posts. The proposed 1994-1995 budget includes the establishment of one national Professional post in information/communication and programme assistant posts in health and water supply, one secretarial and one ancillary post.

41. Although the economic and financial situation of the country and the Government are in a poor state and the central administration is weak, the strategy proposed for the new programme is expected to attract donor support. In fact, the new programme will concentrate at the peripheral level, where work will continue with community involvement and the support of local administration, regardless of changes that may occur at the centre. A more realistic amount of supplementary funds, $5.4 million less than the amount approved by the Executive Board in 1988 (E/ICEF/1988/P/L.5), is now proposed.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Rwanda	(1991 and earlier years)		UNICEF country classification
Under-five mortality rate	189	(1991)	Very high U5MR
Infant mortality rate	112	(1991)	Very high IMR
GNP per capita	$ 260	(1991)	Low GNP
Total population	7.3 Million	(1991)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1991
Births	(Thousands)	198	271	369	382
Infant deaths (under 1)	(Thousands)	28	35	42	43
Under-five deaths	(Thousands)	48	59	70	71
Under-five mortality rate (per 1,000 live births)		242	219	191	189
Infant mortality rate (under 1) (per 1,000 live births)		143	129	113	112

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1976/1982-1983)	Moderate & severe	28	33 a/
	Severe	6	4 a/
Babies with low birth weight (%, 1971/1990)		17	17
% of primary school children reaching final grade, 1980/1988)		47	36

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1985)	94 /85/ 74	97* / 97* / 74*
Prevalence of wasting (%, 1976/1982-1991)	11	1 a/
Prevalence of stunting (%, 1982-1983)	..	34 a/
Daily per capita calorie supply (% of requirements, 1988-1990)	..	82
Food production per capita index (Index 1979-1981=100, 1980/1991)	98	86
Household expenditure (% of total income, 1980-1985)	All food/cereals	30 / 11

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987)			24
Access to health services	Total	..	27
(% of population, 1980)	Urban/rural	.. / ..	60 / 25
Access to safe water	Total	55	50
(% of population, 1980/1985)	Urban/rural	48 / 55	79 / 48
Access to adequate sanitation	Total	51	57
(% of population, 1980/1985)	Urban/rural	60 / 50	77 / 55
Births attended by trained personnel (%, 1979/1989)		25	22
Maternal mortality rate (per 100,000 live births, 1982)		..	210

Immunization		1981	1985	1990	1991
One-year olds (%) immunized against:	Tuberculosis	51	83	92	94
	DPT	17	50	84	85
	Polio	15	56	83	85
	Measles	42	52	83	81
Pregnant women (%) immunized against:	Tetanus	5	21	87	88

TABLE 1 (continued)

Rwanda

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	63 / 59	69 / 65
(%, 1980/1989)	Male	66 / 61	69 / 65
	Female	60 / 57	68 / 65
Secondary enrolment ratio (gross/net)	Total	3 / 2	7 / 7
(%, 1980/1989)	Male	4 / 2	9 / 8
	Female	3 / 1	6 / 6
Adult literacy rate, 15 years & older	Total	32	50
(%, 1970/1990)	Male/female	43 / 21	64 / 37
Radio/television sets (per 1,000 population, 1980/1990)		29 / ..	62 / ..

DEMOGRAPHIC INDICATORS		1970	1980	1990	1991	2000**
Total population	(Thousands)	3728	5163	7027	7271	9766
Population aged 0-15 years	(Thousands)	1862	2665	3629	3772	5085
Population aged 0-4 years	(Thousands)	748	1049	1441	1497	1933
Urban population (% of total)		3.2	4.8	5.6	5.7	6.8
Life expectancy at birth	Total	44	46	47	47	47
(years)	Male	43	44	45	45	45
	Female	46	47	48	48	48
Total fertility rate		8.1	8.5	8.5	8.4	7.4
Crude birth rate (per 1,000 population)		53	53	52	52	48
Crude death rate (per 1,000 population)		21	20	18	18	17

		About 1980	Most recent
Contraceptive prevalence rate (%, 1983)		..	10
Population annual growth rate	Total	3.3	3.1
(%, 1965-1980/1980-1991)	Urban	6.3	4.8

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1991)		1.6	-2.6
Inflation rate (%, 1965-1980/1980-1990)		12	4
Population in absolute poverty (%, 1977)	Urban/rural	30 / 90	.. / ..
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure	Health/education	5 / 19	5*/ 26*
(% of total expenditure, 1980/1987)	Defence	13	..
Household expenditure (% of total income, 1980-1985)	Health/education	3 / 4	.. / ..
Official development assistance:	$US millions	155	328
(1980/1991)	As % of GNP	13	17
Debt service (% of goods and services exports, 1980/1990)		2	11

a/ Indicates data that differ from the standard definition or refer to only part of a country.
* UNICEF field office source.
** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988–1992 a/

COUNTRY: RWANDA
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $7,921,000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSP	GR	FSP	GR	FSP	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	1971	1229	695	436	424	561	1164	943	4254	3163	3169	10643	7423	13806
Household food security and nutrition	118	24	104	161	455		568	130	1245	899	315	1994	1560	2893
Water supply and sanitation	218	643	67	53	521	124	255	756	1061	1449	1576	3835	2637	5284
Education	616	23	457	4	159		592		1824	1490	27	1971	1851	3461
Advacacy, planning and programme support	185		53		295		528	3	1061	920	3		1064	920
Emergency	85								85	84			85	84
Freight	152	10							152		10		162	
GRAND TOTAL	3345	1929	1376	654	1854	685	3107	1832	9682 b/	8005 c/	5100	18443 d/	14782	26448

GR = General resources.
FSF = Funded supplementary funding.
SF = Supplementary funding, funded and unfunded.

a/ Actual expenditure includes expenditure recorded as of 17 December 1992.

b/ Including expenditure from global funds allocation and additional general resources for unfunded supplementary funding programme for health and household food security.

c/ Including $84,000 allocations from the Emergency Reserve Fund.

d/ Of this amount, $8,500,000 remains unfunded.

.../

TABLE 3. PLANNED EXPENDITURE, 1993 – 1997

(In thousands of United States dollars)

Country: RWANDA Period covered: 1993 – 1997	Funding status	1993	1994	1995	1996	1997	Total
Health	GR	693	693	693	693	693	3465
	FSF	160	32				192
	NSF	1040	1040	1040	1040	1040	5200
Household food security and nutrition	GR	297	297	297	297	297	1485
	FSF	200					200
	NSF	260	260	260	260	260	1300
Water supply and sanitation	GR	297	297	297	297	297	1485
	FSF	57					57
	NSF	910	910	910	910	910	4550
Basic education	GR	396	396	396	396	396	1980
	FSF	20					20
	NSF	390	390	390	390	390	1950
Social mobilization and advocacy	GR	297	297	297	297	297	1485
TOTAL	GR	1980	1980	1980	1980	1980	9900 a/
	FSF	437	32				469
	NSF	2600	2600	2600	2600	2600	13000
GRAND TOTAL		5017	4612	4580	4580	4580	23369

GR = General resources.
FSF = Funded supplementary funding.
NSF = New supplementary funding.

a/ Excluding $465,000 balances of additional general resources allocation for unfunded supplementary funding programmes in the previous cycle.

TABLE 4. LINKAGE OF PROGRAMME BUDGET AND STAFFING/STAFF COSTS

RWANDA

PROGRAMME SECTION/AREAS AND FUNDING SOURCES	PROGRAMME BUDGET 1993–1997 (In thousands of US dollars)				POSTS a/ and b/ EXISTING POSTS						SUBTOTAL			TOTAL POSTS	STAFF COSTS a/ (In thousands of US dollars)		
	GR	FSP	NSP	TOTAL	D2/L7	D1/L6	P/L5	P/L4	P/L3	P/L2	IP	NP	GS		IP	LOCAL	TOTAL
GENERAL RESOURCES										d/							
Health	3465			3465				1			1	1	1	3	645	143	788
Household food security and nutrition	1485			1485				1			1		1	2	645	39	684
Water supply and sanitation	1485			1485				1			1			1	645		645
Basic education	1980			1980				1		1	2		1	3	795	39	834
Information, organization and advocacy	1485			1485								1	1	2		143	143
Programme support e/													5	5		192	192
TOTAL GR	9900			9900				4		1	5	2	9	16	2730	556	3286
SUPPLEMENTARY FUNDING																	
Health		192	5200	5392								2	2	4		282	282
Household food security and nutrition		200	1300	1500								1	2	3		183	183
Water supply and sanitation		57	4550	4607								1	2	3		183	183
Basic education		20	1950	1970								1		1		104	104
TOTAL SF		469	13000	13469								5	6	11		752	752
TOTAL GR & SF				23369				4		1	5	7	15	27	2730	1308	4038
ADM. AND PROGRAMME SUPPORT BUDGET (Proposed 1994–1995)	Operating costs			888													
	Staffing b/						1	1	1		3	2	5	10	794	197	991
GRAND TOTAL (GR + SF + ADM)							1	5	1	1	8	9	20	37			
	Number of posts and staff costs:																
	– At the beginning of previous programme (1988)										6	1	9	16	N/A	N/A	N/A
	– At the beginning of proposed programme (1993)										d/ 8	9	20	37	N/A	N/A	N/A
	– At the end of proposed programme (1997) (Indicative only)										9	10	20	39	N/A	N/A	N/A

a/ Each post, regardless of its funding source, supports the country programme as a whole.

b/ The posts are effective as of 1 January 1994.

c/ Project posts are funded for five years and core posts are funded for two years.

d/ Includes 1 UNV.

e/ Spread over various sectors.

Abbreviations: GR = general resources; FSP = funded supplementary funding; NSP = new supplementary funding; SF = supplementary funding; IP = International Professional; NP = National Professional; GS = General Service. ADM = administrative.